APPLICATION OF A BRIEF ECLECTIC PSYCHOTHERAPY PACKAGE FOR ELDERLY LIVING IN OLD AGE HOME

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SYNOPSIS

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STATE-OF-ART:

Global issues arise from aging societies. An aging society is one in which at least 7% of the population is 65 years of age or older, according to the World Health Organization (WHO) (United Nations, 1956). 9.3% of people worldwide are 65 years of age or older as of 2020; Japan has the highest aging rate at 28.6% (United Nations, 2020). 16.2% of the world's population is expected to be 65 years of age or older by 2050 (United Nations, 2020). India is on the verge of becoming an older society, with 10% of the population 60 years of age and older in 2019 (United Nations 2019). By 2050, that number is predicted to rise to 323 million, making up 20% of the country's ageing population(India, H., 2014). As, the life expectancy from birth has increased drastically.

According to the World Health Organization (WHO), old age denotes the decrease in an individual's environmental compliance ability out of her/his control and chronologically defines individuals aged 65 years and older. Based on the chronological age, WHO classified it as follows: 65-75 years define young old ages and a transition period from working life to retirement; 75-85 years define advanced old ages and a period where functional losses begin to be observed; 85 years and older define very advanced old ages and a period that requires special care and support (Ahmad et al., 2001).

According to Özel et al. (2014), the aging process is a natural one that begins after pregnancy and lasts until death. It is brought on by the permanent deterioration of systems and cells. According to Hoca and Türker (2017), aging is not a disease process; rather, it is a series of physiological, psychological, societal, and temporal changes. As a result, the meaning of old age is complicated and wide. According to Tekin and Kara (2016), there are three domains of ageing that are used to express different types of losses: psychological,

physiological, and sociological. Physiological old age is used to express losses in structural and functional losses. Psychological ageing is expressed in loss of perception, learning, and problem-solving ability. And sociological ageing is decline and loss in the values given by society to individuals (Tekin and Kara, 2016).

Like any other life transaction, old age is associated with new developmental tasks and bring new challenges for the individual. "Aging is the progressive accumulation of diverse, deleterious changes with time that increase the chance of disease and death," according to Harman's (2006) definition. Aging is linked to changes in dynamic biological, physiological, environmental, psychological, behavioural, and social processes, according to National Institute on Aging (2020). Certain aging-related changes—like graying hair—are harmless. Others lead to greater vulnerability to and frequency of sickness, frailty, or disability, as well as reductions in the senses' and everyday activities' ability to operate. In actuality, the main risk factor for many chronic diseases in humans is growing older. Growing older brings with it new physical, social, and emotional obstacles as well as changes in cognition and emotion that affect self-control, social connections, decision-making, and subjective well-being. Individuals' independence, emotional health, physical function, social relationships, cognitive function, and economic well-being are all impacted by how they handle these issues.

Apart from the decline cause by normal aging process. Most of the old age people (> 65 years & older) have at least one chronic medical illness, and many have multiple conditions (Pg. 3, Spar & Rue, 2009). According to a study published in the Indian Journal of Community medicine, about 21% of the elderly in India reportedly have at least one chronic disease. Seventeen percent elderly in rural areas and 29% in urban areas suffer from a chronic disease. Hypertension and diabetes account for about 68% of all chronic diseases (Jana & Chattopadhyay, 2022).

According to the Global Burden of Diseases report from 2017, India had 990,9501 fatalities overall. It was estimated that 59% of them belonged to the older population (IHME, 2015). According to the estimate, the leading causes of death for the senior population are cancer, chronic respiratory disorders, stroke, and cardiovascular diseases. The estimations used to reach this conclusion are fairly similar to the data from the Sample Registration System (2010–2013) (Malik et al., 2021). According to the National Mental Health Survey (2015–2016), in addition to medical illnesses, the life prevalence rate of acquiring a common mental disorder is 13.64% for people over 65, while the life prevalence rate of developing depression in the elderly is 6.3%. The rate in the geriatric group was even higher (43.3%) than in the non-geriatric group (4.7%), according to Tiwari et al. (2000). Anxiety (20.9%) and organic diseases (8.1%) were the second most frequent psychiatric disorders among the elderly population, after depression (21.3%). Shahji et al. (2010) conducted a community study on geriatric psychiatric illness and found that the prevalence ranged from 8.9 to 61.2%. An additional comprehensive analysis of research carried out in India between 2007 and 2016 assessed the prevalence of depression among the elderly as 34.4% (Pilania et al., 2019). Hence, this indicate that elderly population faces higher risk of developing medical and psychiatric conditions and make them vulnerable group.

A more thorough examination of the scientific literature reveals that the term "psychological distress" is frequently used to refer to a broad range of symptoms, including personality features, functional impairments, behavioral issues, and symptoms of depression and general anxiety. A condition of emotional discomfort typified by signs of anxiety (such as restlessness and tension) and depression (such as decreased interest, grief, and hopelessness) is sometimes referred to as psychological distress (Mirowsky and Ross 2002). These symptoms might be related to physical symptoms (headaches, tiredness, insomnia, etc.) that are likely to differ between cultures (Kleinman 1991, Kirmayer 1989). Psychological distress

is described as "a set of painful mental and physical symptoms that are associated with fluctuations of mood in most people" by the American Psychological Association in 2007. Psychological distress, however, can sometimes be a sign of the onset of major depressive disorder, anxiety disorder, somatization disorder, schizophrenia, or any number of other clinical illnesses. It is believed to be what is evaluated by numerous purported self-report depression and anxiety tests.

According to the stress-distress model, in particular, exposure to a stressful event that endangers one's physical or mental health, the inability to effectively cope with this stressor, and the emotional turmoil resulting from this ineffective coping are what define psychological distress (Horwitz 2007, Ridner 2004). Psychological discomfort is considered, on the one hand, an emotional disturbance that might affect people's ability to perform in social situations and in their daily lives (Wheaton 2007).

The most prevalent issues affecting the elderly that lead to psychological discomfort include loneliness, neglect and low importance, aging-related sickness, and inadequate medical care (Wrenn & Lizardi, 2020; Zelalem & Gebremariam Kotecho, 2020). The World Health Organization (2020) has also highlighted that psychological distress in older persons can be caused by exposure to adversity, a notable loss in intrinsic capability, and a deterioration in functional ability. The senior population has numerous obstacles to living a respectable life in addition to the difficulties brought on by modernization and normal aging (Cummings et al., 2021; Newman, Prabhu, Akkakanjanasupar, & Tepjan, 2021). The shift in Indian families from conventional joint families to nuclear families regarding composition, functioning, pattern, dynamics, and structure cause additional sources of psychological distress among them. (Kaushik, 2020).

The elderly population in India is growing phenomenally, and at the same time, the size of the family is decreasing, especially in urban areas (Help Age India, 2013). The need

for institutional care for the elderly assumed a new significance across the globe with the progressive increase in the ageing population and the absence of home-based family care. This move has both policy and theoretical implications (Menezes, 2020). In India, the joint family system has long been common, and children, particularly sons, took care of their aging parents. However, the conventional joint family system is dwindling as a result of recent changes in the family structure. Indian society is changing dramatically as a result of globalization, industry, urbanization, technological advancement, and western education. As a result, the intergenerational ties that formed the basis of the traditional Indian family are being weakened by the erosion and adaptation of traditional values and institutions (Elderly in India, 2019). And the care of the elderly has become a major issue in India as the population of the elderly continues to grow with this changing family system.

Elder abuse prevention, social and mental health, and economic and social stability are all important aspects of providing care for the elderly (Blessings, 2020). A growing number of older people are being forced to live alone or move into senior living facilities or old age homes as a result of the nuclearization of the family and recent shifts in the psychological matrix and values. According to S. Akbar et al. (2014), old age homes are starting to take off as a new kind of housing for the elderly and are eventually becoming a need in Indian society. Old age homes provide elderly people with security and medical care; thus, many older persons live there. However, some of them are compelled to relocate into assisted living facilities due to a lack of emotional support, verbal and even physical abuse, neglect, and contempt from their children when they were still living at home (Menezes S. et al., 2018). Children who have grown apart from their parents can live better lives for their parents and let go of their guilt at these retirement communities. This is because their relationship with their parents is better as kids become more independent and have access to all they need (Mittal, 2021). Seniors began to think about other options for their care as a result of these changes.

As a result, most elderly individuals in need of alternative care arrangements end up in institutions since they are either unable to pay for in-home commercialized care or are unable to find such options in their area (Bhat & Druvarajan, 2001).

Elderly people undergo emotional upheaval as a result of their own experience moving from their house to an assisted living facility. Menezes (2020) noted in this qualitative study that early feelings of hopelessness, abandonment, abandonment, despair, and fear about the future were experienced by those who entered the old age home. Long-term, senior living facilities undoubtedly offer security, a degree of independence, and more comprehensive medical care; yet, their effects on the mental well-being and overall quality of life of the elderly are contingent upon a variety of environmental and everyday circumstances. The tight and strict schedules, complete or almost complete isolation from friends, family, and society, anxiety about putting oneself in a new environment, physical decline, and frequent and close encounters with illness and death in the institution are all challenges faced by older adults residing in assisted living facilities. Numerous studies have shown that the prevalence of depression was higher in elderly people living in institutions (75%) than in the community (57.1%) (Praveen et al., 2016). Many of them have virtually no social support, which makes older folks feel as though they don't belong, aren't loved or cared for, aren't respected or cherished (Kumar et al., 2012). Older persons are more susceptible to mental health issues and their negative consequences due to these and other causes (HelpAge India, 2013). When compared to elderly people who live at home, many elders in old age homes experience significant psychological changes and emotional upheaval due to feelings of powerlessness, loneliness, and a lack of emotional support. As a result, these individuals have higher rates of depression, anxiety, and stress. (Menezes & Thomas, 2018; Nagaraj et al., 2011).

PROBLEM TO BE INVESTIGATED

Based on the pilot study problem taken into consideration is to formulate & apply an eclectic psychotherapy approach for elderly living in old age home to manage psychological distress among them. The psychological distress is defined as set of painful mental and physical symptoms that are associated with normal fluctuations of mood in most people. The intervention will aim to reduce the level of Anxiety & Depression among them and will focus on to enhance their Self Esteem, Perception of Age, Meaning-in-Life so that quality of their life (QOL) can be enhanced. The package will be applied on experimental group (elderly with high level of distress getting intervention) while keeping the control group (elderly with high level of distress on usual care) for comparison to ensure its applicability.

OBJECTIVES & MOTIVATION BEHIND THE STUDY

Objectives:

1. To explore the possible factors which are associated with the psychological distress among elderly living in old age home.
2. To assess the applicability & sustainability of eclectic psychotherapy approach for elderly on their clinical parameter (Depression & Anxiety)
3. To assess the applicability & sustainability of eclectic psychotherapy approach for elderly on their psychological parameter (Self Esteem, Perception of Age, Meaning-in-Life & Quality of Life).
4. To structure a brief eclectic psychotherapy package for elderly with psychological distress on the basis of therapeutic outcome of the study.

Motivation behind the Study:

Old age is generally associated with loss (like retirement, losing autonomy, physical capabilities, family roles, loss of spouses/close friends or relatives etc) which make them

marginalize and cause psychological distress among them. In today's fast developing world, family system in India is changing drastically from joint to nuclear because of these elderly is either moving to old age home or living alone for different reasons, this makes them double marginalized in the community apart from facing a series of loss associated with old age. Researchers has reported that mental health issues like depression, anxiety, stress, dementia, loneliness are more prevalent among elderly living in old age home and this shows that they are at high risk of developing severe medical or psychiatric condition. Researchers has also indicated that transition to old age home bring meaninglessness & lack of life satisfaction among them which cause a hinderance in experience of healthy aging. Hence, there is a need to cater the psychological needs of elderly living in old age home to enhance their quality of their life by reducing their risk of developing severe medical or psychiatric condition and making them move towards the healthy aging continuum is needed.

HYPOTHESIS & RESEARCH QUESTION

Phase 1

Research Question:

- What is their perception about Aging?
- How do they perceive the meaning of the shifting to old age home?
- How did they manage or adjust to the current situation?
- How meaningful do they perceive their experience of living in old age home?

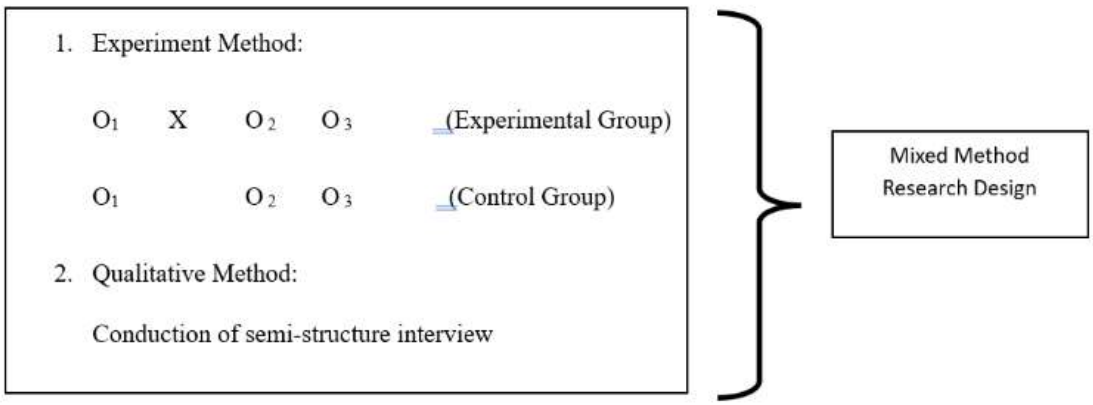
Phase 2 & 3

Hypothesis

- There will be no significant differences between Experimental group and Control group on clinical parameter (Depression, Anxiety) among elderly with psychological distress living in old age home in Pre-Post Assessment.
- There will be no significant differences among Experimental group and Control group on psychological parameter (Self Esteem, Perception of Age, Meaning-in-Life & Quality of Life) among elderly with psychological distress in Pre-Post Assessment.
- There will be no significant differences among Experimental group and Control group on clinical parameter (Depression, Anxiety) among elderly with psychological distress in Post-Follow Up Assessment.
- There will be no significant differences among Experimental group and Control group on psychological parameter (Self Esteem, Perception of Age, Meaning-in-Life & Quality of Life) among elderly with psychological distress in Post-Follow Up Assessment.
- The eclectic psychotherapy approach will be applicable for elderly with psychological distress living in old age home.

RESEARCH DESIGN & METHODOLOGY

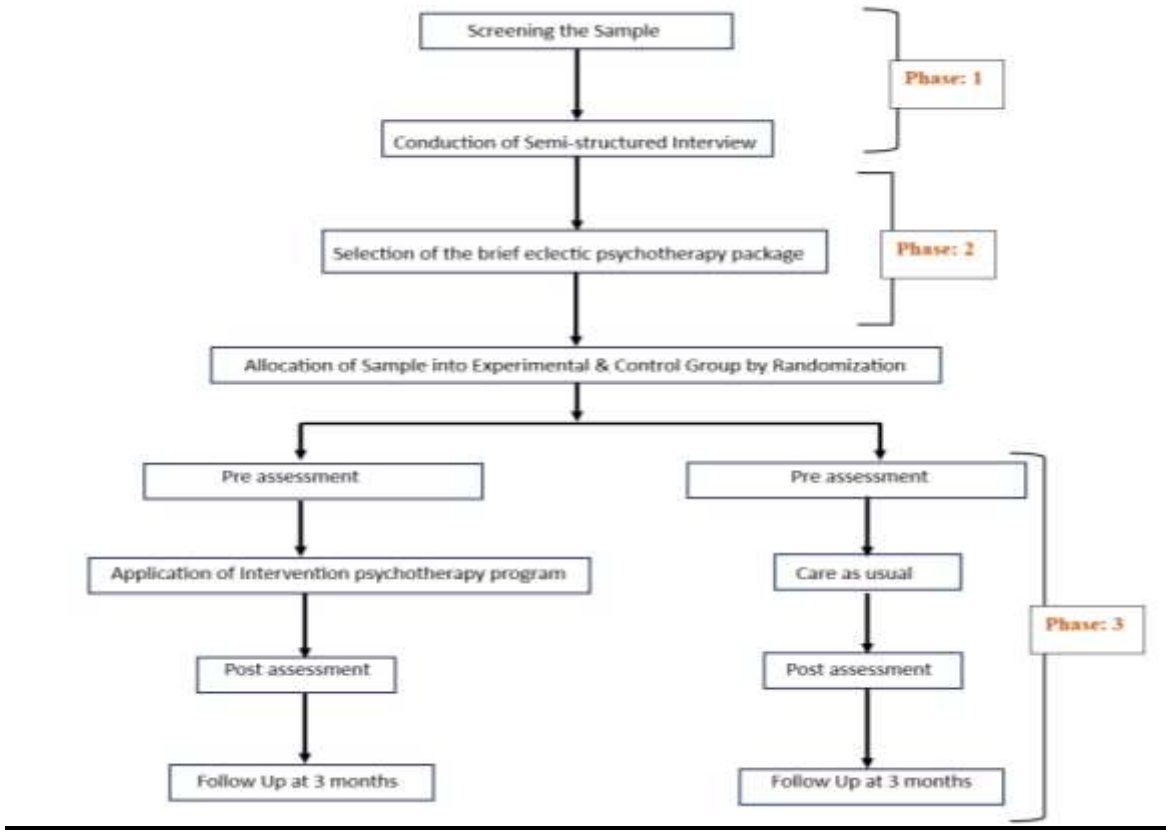
Design of the study: A residential care-based study (using mixed methods) will be conducted with elderly living in old age home using Pre-test and post-test control group design



O_1: Pre-test Observation, X: Intervention; O_2: Post-test Observation, O_3: Follow up Observation

Figure 1: Research Design for present study

PROCESS



Phases of the study:

The study was conducted in three phases

• Phase 1: Exploring the subjective experience and perception of elderly living in old age home to identify the possible factors which can cause psychological distress among them.

• Phase 2: Selection of brief eclectic psychotherapy package.

• Phase 3: Screening and assessing the applicability & sustainability of the brief eclectic psychotherapy package on elderly living in old age home.

Phase 1: Exploring the subjective experience and perception of elderly living in old age home to identify the possible factors which can cause psychological distress among them.

In the first phase of the study, the aim will be to identify the possible causative and protective factors related to psychological distress among elderly living in old age home by individual in-depth semi-structure interview.

Phase 2: Selection of the brief eclectic psychotherapy package.

In the second phase, based on the common factors & literature review, a brief eclectic psychotherapy package will be formulated by selection of evidence based therapeutic techniques to provide intervention to elderly with psychological distress living in old age home aiming to enhance to reduce the psychological distress.

***Table 1:** **Based on pilot study and literature review tentative evidence based therapeutic techniques are included to cater the following components which will be used in formation of final therapy session plan:**

Component	Therapy (Techniques)
Psychoeducation	• Providing the information about the healthy aging and its correlation with mental health. Further how it impacts the physical health of the individual as well.

Psychotherapeutic Alliance	• Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe

Perception about Aging:

Perception about aging	• **Validating the emotions** attached to the distorted perception about the aging and changes associated to it. • **Radical Acceptance:** Accepting the reality mindfully without changing judgement attached to it. • **Role Change** to what are their new roles in their life and how they are adapting it? • **Minimization of Demandingness:** helping the client to reduce the expectations from the life as per the changes family system.
Sense of Control	• **Body scanning relaxation & sitting yoga:** to enhance their sense of control over their body. • **Habit rehearsal:** According to the need of the client cultivating the customized daily activity plan. • **Socratic Questioning:** Do you feel you can control your life at this phase? How? • **Responsibility Emphasis:** explaining the concept of theory of choice to emphasis the role self-responsibility in cultivating healthy lifestyle & reducing risky consequences.

	• **Future Orientation:** to help clients focus on what they can do now and, in the future, to achieve their wants and needs.
Emotional Representation	• **Mindfully observe & attend the emotions** attached to it without judgement. • Focusing on **Here & Now** instead of worrying about future • **Developing Spiritual Coping:** Pray, Practicing Gratitude.

Anxiety:

Identity	• **Existential Questioning:** How their experience if identify shifted from before shifting to old age home and after? By write: Who am I? and How shifting to old age home affected my identity? • **Reflection of past success:** Describe your achievements in your life. • **Inculcating their dignity:** What were most important role you have played?
Meaning about Life	• **Socratic Questioning:** • **Creative Sources of Meaning:** Do you have unfinished business? What tasks have you always wanted to do, but have yet to undertake? If so, what do you think is holding you back? • **Experiential Sources of Meaning:** List three ways in which you connect with life and feel most alive the experiential sources of Love, beauty, and humour (three examples each)
Social Isolation	• **De-reflection:** This aimed at helping the client to focus away from themselves and toward other people allowing them to become

	"whole" and to spend less time feeling preoccupied with a problem or worry**.** • **Life engagement activity:** as per the interest of the client • Teaching Emotion-regulation skills
Death Anxiety	• **Relaxation Therapy:** for physiological arousal • Processing emotions related to grief by **self-awareness** • How the loss impacted them? • Brining acceptance of the loss. • Giving spiritual oriented coping techniques • **Reconstructing the meaning** attached to the loss by using their narration • **Attitudinal Sources of Meaning:** What would you consider a "good" or "meaningful" death? How can you imagine being remembered by your loved ones? (e.g., what are some of your personal characteristics, the shared memories, or meaningful life events that have made a lasting impression on them?)

Depressive Cognition:

Negative Mood	• **Identifying triggers (**situations/ thought) which leads to experience of negative mood. • **Positive self-talk** • **Counting on the things you are blessed with**
Hopelessness	• **Hopeful imagination** • **Narrating encouraging stories** of resilience and positivity that might

	inspire the individual. • Cultivating **Faith Based positive thoughts**
Pre-existing Trauma/ Guilt	• Exploring the presence of pre-existing trauma/ guilt • Ask the client to write the narration about the event • Changing the thought by **cognitive restructuring** • **Body scanning technique** for sensational processing (if present)

Termination Session:

Self-Reflection after therapy	**Client feedback diary**

Phase 3: Screening and assessing the applicability & sustainability of the brief eclectic psychotherapy package on elderly living in old age home.

In the third phase of the study, the screening of the possible of the population will be done. After that the brief eclectic psychotherapy package will be applied on the elderly (experimental group) living in old age home with psychological distress.

SAMPLE OF THE STUDY

A total of 30 elderly living in old age home having high psychological distress fulfilling the inclusion and exclusion criteria will be selected from Old Age Home, Ranchi using purposive sampling technique for the study. Amongst these, 15 elderly will be randomly assigned to the experimental group and 15 to the control group. Brief eclectic psychotherapy package will be provided to the experimental group along with care as usual, whereas the

control group will be provided with care as usual only. Following inclusion and exclusion criteria will be followed:

INCLUSION AND EXCLUSION CRITERIA

Inclusion criteria

- Elderly living in Old Age Home for at least 6 months
- Age range of 65 – 85 years
- Male and Female
- Able to read and write Hindi/English language
- Willingness to participate and providing informed consent

Exclusion criteria

- History of major psychiatric illnesses
- History of chronic substance abuse
- History of concurrent severe or chronic medical disease other than diabetes and hypertension
- High suicide risk
- Elderly with severe comorbid depression or anxiety disorders
- Elderly with moderate to severe cognitive decline

SOURCE OF THE DATA AND TOOLS FOR DATA COLLECTION

Venue:

This proposed study will be carried out at Old Age Home (Bariatu, Ranchi)

Tools:

1. Socio Demographic Sheet

2. Mini Mental Status Examination (MMSE)
3. Kessler Psychological Distress Scale (K10)
4. Geriatric Depression Scale
5. Existential Anxiety Scale
6. Brief Perception of Aging Questionnaire
7. Rosenberg Self Esteem Scale
8. Meaning-in-Life Questionnaire
9. World Health Organization-Quality of Life- BREF

c. Client Feedback Diary

Description about the Tools:

1) Mini Mental Status Examination (MMSE):

Since its creation in 1975 (Folstein & McHugh, 1975), the mini-mental state assessment has been applied extensively in both clinical and research contexts. An experienced administrator can finish the 30-item screening tool in around ten minutes. A score of (≤9 points), moderate (10–20 points), and mild (21–24 points) indicates severe cognitive impairment. Normal cognition is indicated by a score of 25 or higher.

The MMSE was translated and modified into the Hindi mental state examination (HMSE) (Ganguli et al., 1995) to screen the elderly rural people who do not know Hindi and are illiterate. Similar to the MMSE, the maximum score is 30 if every question is answered correctly. It is accessible without charge. It has strong psychometric qualities.

2) Kessler Psychological Distress Scale (K10):

A straightforward tool for measuring psychological distress is the Kessler Psychological Distress Scale (K10), which was created by Kessler et al. (2002). Adults 18 and older can use it. Ten items concerning emotional states are included in the K10 scale,

each having a five-level response range. The measurement can be used as a quick screening tool to determine distress levels. The subscales consist of two primary items: Items 1, 4, 7, 8, 9, 10) and Items 2, 3, 5, 6 relate to anxiety and depression, respectively. Patients or clients can either be given the tool to complete or have the practitioner read the questions to them. Scores range from one for "none of the time" to five for "all of the time" for each item. Scores of the 10 items are then summed, yielding a minimum score of 10 and a maximum score of 50.

A set of cut-off scores was adopted by the Victorian Population Health Survey (2001) to serve as a guide for screening for psychological distress. These are the following: a) 10-19 Probably in good health. b) 20–24 Very likely to develop a minor illness. c) From 25 to 29 Most likely a moderate condition. d) Between 30 and 50 likely to suffer from a serious illness. K-10 is the best option for estimating the prevalence of clinically significant psychological distress, with sensitivity = 53% and specificity = 97%. As a result, it is thought to have strong psychometric qualities and can be used for screening.

3) Geriatric Depression Scale-30:

A self-report tool for assessing depression in older persons is the Geriatric Depression Scale (GDS). Users reply using a binary system (Yes/No). The GDS was first created and validated as a 30-item instrument by Yesavage et al. (1983), then Ganguli et al. (1999) translated it into Hindi. Every item is assigned a score of either "0" or "1," with a maximum score of 30. According to Thomas et al. (2021) a score of ≤9 is regarded as normal, 10–19 as mild depression, and 20–30 as severe depression. According to Yesavage et al. (1983), the scale has been found to have a good degree of internal consistency and high sensitivity (92%–100%) and specificity (84%–87%) for diagnosing depression in older persons.

4) Existential Anxiety scale:

The tool was created to evaluate the crucial areas of existential anxiety as described in Tillich's (1952) research. The 13-item questionnaire evaluates the six existential anxiety domains—meaninglessness, death, fate, emptiness, guilt, and condemnation—that make up Tillich's notion of existential anxiety. For each of the six concepts (three items for "fate"), there are two questions that are half positively and half negatively written; of these, one question is positively rated and the other two are negatively.

The 13-item EAQ had a mean score of 5.28 (SD = 2.8), and the distribution of scores was pretty normal, with a skew that was somewhat positive (skew =.48). The EAQ demonstrated adequate internal consistency (coefficient alpha =.71) and a two-week test-retest reliability estimate of r =.72, according to the results of reliability assessments (Weems, 2004).

5) Rosenberg Self Esteem Scale:

Item response theory was used to examine the Rosenberg Self-Esteem Scale, a popular self-report tool for assessing individual self-esteem. Morris Rosenberg developed the RSES in 1965. a 10-item survey that gauges one's overall sense of worth by accounting for both positive and negative self-perceptions. It is thought that the scale is one-dimensional. A 4-point Likert scale, ranging from strongly agree to strongly disagree, is used for all item responses (Rosenberg, 1965). There are multiple versions of the RSES and it is public domain, so it can be modified for certain purposes.

It is common to employ the RSES. It has been examined in at least 53 countries and translated into at least 28 languages. According to Google Scholar, as of February 2020, it had been cited more than 40,000 times and was included in about half of the empirical studies on self-esteem that were published in prestigious scientific publications (Park & Park, 2019; Monteiro et al., 2022)

6) Brief Age Perception Questionnaire:

The Brief Ageing Perceptions Questionnaire (B-APQ) is a simplified version of the 32-item Ageing Perceptions Questionnaire (APQ), a multi-dimensional assessment based on Leventhal's self-regulation paradigm. It was developed by Bellinda L. King Kallimanis, Karen Morgan, Hannah Mc Gee, and Eithne Sexton (2014). The B-APQ is a quick, multi-dimensional measure of aging perceptions that shows psychometric validity when administered to Irish individuals 50 years of age or older, according to Sexton et al. (2014). It comprises seventeen measuring components. Age perception in five dimensions Among these are: a) Timeline (perceptions of aging as a continuous process). It consists of awareness of aging continuously and varyingly, or timeline-chronic and timeline-cyclical consciousness of aging, respectively. Consequences has both positive and negative sub-dimensions and is related to perceptions about the effects of aging. Beliefs regarding one's degree of control over the positive and negative elements of aging are related to control. Lastly, negative emotional reactions to aging, such as concern, anxiety, and despair, are referred to as emotional representations.

The original's construct validity and internal consistency were maintained in the condensed form. Because of its briefness, it is especially well suited for usage in extensive adult population surveys. The self-regulation model's applicability to age perceptions is supported by the psychometric analysis (Sexton et al., 2014).

7) Meaning-in-Life Questionnaire:

It was created in 2006 by Steger, Frazier, Oishi, and Kaler with the intention of determining an individual's meaning in life. The 10-item test is intended to assess two aspects of meaning in life: (1) Presence of Meaning, or the degree to which respondents believe their lives have purpose, and (2) Search for Meaning, or the degree to which respondents look for purpose and understanding in their lives. Each question is answered by respondents using a 7-

point Likert scale, with 1 denoting "absolutely true" and 7 denoting "absolutely untrue." Excellent test-retest stability, stable factor structure, convergence among informants, and reliability characterize the MLQ. Presence correlates as predicted with self-assessments of one's own personal development as well as with acts of kindness and spirituality evaluated by daily diaries (Steger, 2010). Unlike certain assessments of psychological diseases, the MLQ does not have cut scores. Its goal is to gauge life's significance across the whole gamut of human functioning. It takes three to five minutes to finish the MLQ. According to Steger et al. (2006), the MLQ exhibits strong internal consistency, with coefficient alphas for the Presence subscale ranging from low to high in the.80s and the Search subscale from mid-.80s to low in the.90s.

Life's purpose Kamlesh Singh, Mohita Junnarkar, Snehlata Jaswal, and Jasleen Kaur (2016) validated the questionnaire in Hindi. MLQ-H revealed a two-factor structure explaining 56.42% of variation, in line with the original factor structure, and confirmatory factor analysis was established. High internal consistency was shown by both factors, with Cronbach's α values of.78 (MLQ-S) and.81 (MLQ-P).

8) World Health Organization-Quality of Life- BREF, Field Trial Version (WHOQOL-BREF):

A person's evaluation of their position in life in respect to their values and culture, as well as their objectives, expectations, and concerns within that culture, is known as their quality of life, according to the WHO. The World Health Organization developed the WHOQOL-BREF, a 26-item shortened version of the WHOQOL-100. To give a thorough assessment, the WHOQOL-100 abbreviated version contains one item from each of the 24 components. Two questions from the Quality of Life and General Health sections were also included in the scale. The instrument is a 15-minute self-administered scale that assesses four

areas of an individual's well-being: social interactions, environmental influences, psychological well-being, and physical health. Every item on the WHOQOL-BREF is evaluated on a response scale that is defined as a five-point ordinal scale. Higher values indicate higher quality of life (QoL). Each item is scored on a Likert scale from 1 to 5, with variable scale response anchors.

Excellent test-retest reliability, content validity, and discriminant validity have all been demonstrated by the WHOQOL-100 and WHOQOL-BREF. For this study, a translated version of the scale developed by Saxena et al. in 1998 was utilized. The instrument demonstrated strong content, construct, and predictive validity (p values 0.05) as well as good internal consistency (Cronbach's = 0.87; p-value 0.01) in a validation research with an Indian adolescent sample. The overall QOL score (psychological) was substantially correlated with all features and domains, ranging from r =.18 (environmental quality) to r = 0.65 (psychological wellbeing).205 Even though each domain has a wide range of features, each domain exhibits exceptional internal consistency. By using confirmatory factor analysis on the data from the field trial, the new centers, and the original pilot, valid comparative fit indices were found (CFI =0.906, 0.903, and 0.87, respectively).

DATA ANALYSIS

Appropriate statics will be done with the help of Statistical Package of Social Sciences (SPSS) to perform inter-group comparison between experimental and control group and intra-group comparison will be for experimental and control group independently.

SIGNIFICANCE OF THE STUDY

The present study will contribute to the field of Gero-psychology in the psychological management of elderly with psychological distress through the development of an eclectic psychotherapy package and its assessment of applicability among the elderlies. The

therapeutic model will be integrating the various evidence based psychotherapeutic approaches like cognitive restructuring, relaxation therapy, acceptance & commitment therapy, interpersonal therapies meaning oriented psychotherapy and Reminiscence therapy. The proposed module will be helpful in managing psychological distress among elderly, and improving associated clinical and psychological parameters.

RELEVANCE TO PRESENT DAY PROBLEM AND NEED OF THE SOCIETY

Old age home has become a need in today's fast developing world as family system in India is changing drastically from joint to nuclear. But still the elderlies have not gain acceptance towards living in old age home cause them to experience loneliness, stress, sadness and meaninglessness towards life and resulted in mental health issues like depression and anxiety and keeping them at high risk of developing severe medical or psychiatric condition and becoming obstacle in the way of experiencing healthy aging. Hence, there is a need to identify the best practices to treat them which can help them to live a meaningful life. This brief eclectic psychotherapy package will aim to enhance their quality of their life by reducing the risk of developing severe medical or psychiatric condition and making their life meaningful.

CONTRIBUTION TO THE EXISTING KNOWLEDGE

Researches have indicated that among elderlies depression, anxiety, dementia, somatization are the most common psychological morbidity. Although it is not that every elderly will develop the sever level of psychological morbidity, but with aging every elderly faces the gradual cognitive decline, physical decline, independent functioning which ultimately impact the psychosocial functioning and quality of life of the elderly. Along with this age associated stressors, change in the family system (moving to old age home) make them more vulnerable towards psychological morbidities. Hence development of a

management programme addressing their psychological needs in the psychological distress is essential to ensure better outcome in therapy and improve the functional status of the elderly living in old age home. Within the best knowledge of the researcher no such treatment exists specific treatment plan exist so far for elderly living in old age home as still researcher are trying to find out the best practices to reduce their psychological stress and improving quality of life and hence a huge gap of knowledge exists. The formulation and application of brief eclectic psychotherapy package will enrich the existing scientific knowledge in management of elderly with psychological distress who are living in old age home. It may stimulate development of similar management strategies in other disorders as well. The formulation of the therapy package also takes socio-cultural aspects into account and hence can result in proper adaptation of techniques used elsewhere. This will address the problem of cultural unsuitability of existing therapies hindering the real testing of their efficiency in producing desired outcome. Such adaptation may also stimulate similar researches in other disorders which will further contribute to the development of culture specific treatment procedures in the respective disorders.

FUTURE WORK

Future research may be carried out in the respective area contributing to more understanding considering following issues.

- A therapeutic management program can be considered to be effective only if the gains obtained through its application is being generalized. Hence generalization and long-term follow-up is an important issue. It is suggested that a large clinical population may be chosen for study in future for better understanding of the findings and establishing the effectiveness.

- Adoption of randomized clinical trial with different clinical population is also recommended as it will help to assess the effectiveness of the therapy in a better manner.
- Adoption of randomized clinical trial with placebo or an equivalent therapy is also recommended as it will help to assess the effectiveness of the therapy in a better manner.

***Note:** This synopsis is tentative, which may be modified or changed based on the availability of cases, tools, techniques and other situations.

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